DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

MENTAL HEALTH PARITY FOCUSED SURVEY

PILOT TEST #2

FINAL REPORT

California Physicians' Service

dba Blue Shield of California

U.S. Behavioral Health Plan, California

DATE ISSUED TO PLAN: AUGUST 19, 2005
DATE ISSUED TO PUBLIC FILE: SEPTEMBER 1, 2005

CONTENTS

EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a Focused Survey of California Physicians' Service dba Blue Shield of California (the "Plan") and U.S. Behavioral Health Care, California (the "Delegate") from March 21 to March 24, 2005. A "focused survey" assesses compliance of a particular aspect of plan operations with the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene"). In this case, the Focused Survey assessed compliance of the Plan's delivery of mental health services. (Section 1374.72 of the Health and Safety Code, Severe mental illnesses; serious emotional disturbances of children) Blue Shield of California was the second focused survey completed of seven focused surveys conducted between March and June 2005. Plans that were surveyed are Knox-Keene licensed full service plans and, if applicable, specialty mental health plan delegates that administer and provide mental health benefits and services on behalf of the full service plan.

Health and Safety Code Section 1374.72, often referred to as the "**Parity Act**," requires full-service health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions. Rule 1300.74.72 requires health plans to provide timely access and referral for the diagnosis and treatment of conditions set forth in Section 1374.72. The Rule also requires full-service health plans that contract with specialty mental health plans for the provision of mental health services to monitor the collaboration between the two contracting plans and ensure the continuity and coordination of care provided to enrollees.

The Plan delegates the provision of mental health services to the Delegate. At the time of the survey, the Delegate provided mental health services to approximately 99% of the Plan's enrollees (See Appendix B).

Background

Blue Shield of California was founded in 1939 by the California Medical Association as California Physicians' Service. It operated under Section 10810 of the Corporations Code as a nonprofit corporation for medical services. Blue Shield continues to operate as a not-for-profit corporation.

Blue Shield was licensed as a California Health Care Service Plan in July 1978 for its PPO products. It introduced HMO products in 1987. In 1997, the Plan introduced a POS product that allowed enrollees to self-refer within their chosen medical groups. Also in 1997, the Plan acquired Care America Health Plans, a for-profit HMO, which was merged into Blue Shield.

Prior to the passage of the Parity Act, the Plan provided mental health benefits through its capitation contracts with IPAs and medical groups and direct contracts with mental health providers. In order to comply with the provisions of the Parity Act, the Plan contracted with the Delegate in June 2000 to arrange for and be responsible for all covered in-network mental health and substance abuse services provided to Blue Shield enrollees. Under the terms of the Group Service Agreement between the Plan and the Delegate, the Delegate serves as both the mental

health and substance abuse administrator and the provider for HMO enrollees and for in-network services for PPO members. The Plan continues to be financially responsible for all out-of-network PPO and POS services.

The Delegate was incorporated in 1988 in the state of California. In January 1997, United Behavioral Systems, Inc., merged into U.S. Behavioral Health, which then changed its name to United Behavioral Health. The Delegate is a wholly owned subsidiary of United Behavioral Health, which is a subsidiary of United Health Group, Incorporated, a publicly held Minnesota corporation.

The Delegate provides mental health and substance abuse services to approximately 2.3 million Plan enrollees. Additionally, the Delegate is party to partnership agreements with four Knox-Keene full-service health care service plans. Under these agreements, the Delegate is responsible for providing oversight for the treatment of parity diagnosis services for approximately 200,000 enrollees.

Survey Results

As part of the Focused Survey, the Department assessed the Plan's operations in the following four (4) major areas as they relate to the Parity Act: **Access and Availability of Services, Continuity and Coordination of Care, Utilization Management/Benefit Coverage,** and **Delegation Management**.

The Department identified two (2) deficiencies in the Plan's implementation of and compliance with Section 1374.72 (see Section III, Table 1). The Plan has implemented corrective actions for these deficiencies. Based on its review of the documents submitted by the Plan in its response, the Department has determined that the Plan has corrected both of these deficiencies.

Please refer to Section III for a detailed discussion of the deficiencies, the Departments findings, required corrective actions, the Plan's response and compliance efforts, and the Department's final determination regarding the status of the deficiencies.

SECTION I. FOCUSED SURVEY BACKGROUND

The Department's authority to conduct surveys comes from Knox-Keene, which mandates that the Division of Plan Surveys ("Plan Surveys") conduct on-site medical surveys of all licensed health plans at least once every three (3) years, including full-service and specialized plans. Full service health plans are defined as plans that provide all basic health care services. Specialized plans include behavioral health, vision, dental, and chiropractic plans.

In its planning for 2005, the Department's administration directed the Plan Surveys to design a focused survey process to review health plan compliance with enacted mental health parity laws. The project planning began in November 2004 and included three phases:

(1) Stakeholder input, inclusive of several meetings held to gather comments and identify issues currently voiced in the mental health community;

(2) Operations phase, included survey tool development and scheduling of the surveys; and

(3) Conduct the surveys.

The Department supports continued discussions with stakeholders and have received comments and suggestions throughout the project.

The purpose behind the focused surveys was to assess specific plan compliance and also to research some of the problems voiced by stakeholders, such as inadequate access to mental health providers and lack of payment of emergency mental health services. Meeting the challenges of implementation of the parity law from the health plan perspective was addressed with Plan management during the first day of the focused survey.

The Focused Survey Approach

Focused surveys give the Department the ability to swiftly respond to potential serious health plan problems and concerns of consumers, legislators or Department divisions on a particular issue. Focused reviews could include assessment of compliance with legislation, such as the Parity Act, or specific applications, such as Diabetes supplies regulations.

Although Section 1374.72 is reviewed by the Department for compliance as part of the normal routine medical survey process, this focused survey approach allowed a more detailed look at application and compliance.

SECTION II. SCOPE OF WORK

The subject of this Focused Survey is Health and Safety Code Section 1374.72, Rule 1300.74.72, and other relevant sections of Knox-Keene, including but not limited to:

- Determining whether the plan and its contracted mental health plan have developed and maintained adequate provider networks to promote timely access to mental health services;
- Determining whether the plan and its contracted mental health plan are effectively coordinating the care of enrollees and providing continuity of care; and
- Determining whether the plan and its contracted mental health plan are authorizing and providing medically necessary services mandated under Section 1374.72 in an appropriate and timely manner.

Specifically, the Department assessed the Plan's operations in the following four (4) major areas as they relate to the Parity Act:

- Access and Availability of Services – to determine whether the Plan designs benefits for parity diagnoses under the same terms and conditions applied to other medical conditions, whether the Plan clearly communicates those terms and conditions to enrollees, and whether the Plan has developed and maintained adequate provider networks to assure enrollees timely access and referral to mental health services.
- Continuity and Coordination of Care – to determine whether the Plan provides appropriate continuity and coordination of care for enrollees with parity diagnoses.
- Utilization Management/Benefit Coverage – to determine whether the Plan appropriately authorizes and provides medically necessary treatment and services required under Section 1374.72 to enrollees with parity diagnoses.
- Delegation Management - when applicable, to determine whether the Plan adequately and appropriately oversees its contracted specialty mental health plan and ensures that parity mental health services are provided to enrollees with parity conditions in a timely and appropriate fashion, under the same terms and conditions applied to medical conditions.

SECTION III. SURVEY FINDINGS

The table below lists deficiencies identified during the Focused Survey. The Department issued a Preliminary Report to the Plan regarding these deficiencies on April 29, 2005. In the Report, the Plan was instructed to: (a) develop and implement a corrective action plan for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

TABLE 1: DEFICIENCIES

#	SUMMARY OF DEFICIENCIES	Status
A. ACCESS AND AVAILABILITY OF SERVICES		
1	**The Plan does not ensure that providers' provisions for after-hour services are reasonable and that providers respond to enrollee messages in a timely manner.** [Rule 1300.67.2(b) and Rule 1300.74.72(f)]	Corrected
B. UTILIZATION MANAGEMENT/BENEFIT COVERAGE		
2	**The Plan incorrectly and inappropriately denies payment of emergency claims.** [Section 1371.37 and Section 1371.4]	Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan does not ensure that providers' provisions for after-hour services are reasonable and that providers respond to enrollee messages in a timely manner. [Rule 1300.67.2(b) and Rule 1300.74.72(f)]

Documents Reviewed:

- Policy and Procedure After Hours Disposition – revised March 05
- Application for network participation
- Clinician Manual
- Clinician Site Audit tool
- After-hours daily inpatient case report
- Template contract between the Delegate and individual providers

Department Findings: Through a 24-hour toll-free telephone service, the Plan's Delegate provides access to Member Services personnel and clinical personnel 24 hours a day/365 days a year. By means of this telephone service, the Delegate provides enrollees with referrals for appointments, initial authorizations for services, crisis intervention, responses to questions about coverage and benefits and, if necessary, arrangements for emergency care or hospitalization. While the Plan makes in-bound call center services available 24 hours a day through the Delegate, it does not ensure after-hours availability of its providers should an enrollee attempt to contact his/her provider directly. Additionally, because many mental health practitioners operate in solo practices, they are often not available to answer the phone even during normal business hours (e.g., during counseling sessions). An enrollee desiring to contact a provider (either for an initial appointment or as a continuing patient) will, therefore, often reach the same answering machine message or answering service that the provider uses for after-hours coverage. Both after-hours and during business hours, the Plan must ensure that providers have made reasonable provisions for service.

In the Delegate's "Clinician Manual", the Plan specifies that providers must arrange "coverage for emergencies while you are unavailable," inform consumers about "hours of operation and how you can be reached after normal business hours in case of an emergency" and "provide or arrange for the provision of advice and assistance to consumers in emergency situations 24 hours a day, seven days a week." Through its Delegate, the Plan collects information on its clinician application regarding coverage arrangements (stating that "advising patients to call 911 is not sufficient") and reviews that "the clinician makes arrangements for emergency coverage for all patients 24 hours per day/7 days per week (review how coverage is provided)" during provider office audits. The Plan has not, however, established clear criteria regarding what types of arrangements and/or message content are acceptable to guide its providers in establishing their systems and to guide its own evaluation of those systems. Additionally, the Plan does not have a formal means of monitoring whether providers respond to messages.

The Department surveyed 25 providers by telephone during normal business hours to assess provider responsiveness, appointment availability and whether the practice was open to new patients (see Table 2). If the provider or provider staff did not answer the call, the Department assessed:

(1) whether an answering machine message or service was in place, and
(2) whether the message contained a pager number or answering service by which the enrollee could reach the provider, and
(3) whether there were instructions to contact 911 in the event of an emergency.

The Department also left a message requesting a return call and monitored whether a return call was received within 24 hours. The Department found that, of the 22 calls that were not answered by the provider or provider staff, 21 were answered by a service or had an operational messaging system. One system was not operating correctly. Of the 18 that had a message machine, only three (3) messages contained instructions regarding use of 911 for emergencies. Two (2) of those messages and five (5) additional messages (total of 7 messages) contained other instructions regarding emergencies or after-hours contact methods (e.g., provider pager number, crisis line referrals).

Of the 21 providers with whom messages could be left, 14 responded with a return call within 24 hours; the remainder did not. The Department also performed a telephone survey of 10 providers after normal business hours to assess the presence and content of answering service/machine messages. Two (2) calls were answered by answering services and the remaining eight (8) were answered by machines. Of the eight (8) answered by machines, three (3) directed patients to call 911 for emergencies. Two (2) of the messages with 911 instructions and three (3) additional messages (total of 5 messages) included other instructions for emergencies or after-hours contact.

TABLE 2: TELEPHONE SURVEY OF PROVIDERS

TOTAL CALLS			IF NOT ANSWERED BY PROVIDER/STAFF (Total = 22 business hours, 10 after-hours)				IF ANSWERED BY PROVIDER/STAFF OR CALL BACK RECEIVED (Total = 17)	
				If machine:				
Sample type and Size	Answered by Provider or Office Staff	No Answer by Provider or Office Staff	Answering machine (M) or service (S) present	Direct enrollee to 911	Additional emergency instructions (e.g., pager, crisis line #)	Call back received within 24 hours	Open to new patients	Meets Plan's routine appointment availability standard of 10 working days
Calls during business hours = **25**	3	22	M=18 S=3 None=1	3	7	14	16	14
Calls after hours = **10**	0	10	M=8 S=2	3	5	N/A	N/A	N/A

Implications: Although an enrollee may initially contact the 24-hour line to arrange for services and may contact the Delegate at any time to arrange for emergency care, once an enrollee has established a counseling relationship with a provider, that enrollee may attempt to contact the provider prior to or instead of contacting the Delegate in an emergency or urgent situation. For this reason, access to individual providers after hours must be ensured and/or clear instructions provided via provider messaging systems regarding how patients may contact the provider and/or other sources of assistance. Additionally, in order to facilitate: (a) prompt handling of current patients' needs, and (b) expeditious responses to calls for new appointments, the Plan must ensure that providers respond in a timely manner to messages left for providers by enrollees.

Corrective Actions: The Plan shall provide evidence that its Delegate has developed and distributed to its providers clear and detailed instructions regarding its requirements for after-hours coverage and messaging.

The Plan shall also provide evidence that a system has been established for monitoring the presence and content of provider answering system messages and for monitoring the timeliness of providers' responses to messages left by enrollees.

It is suggested that results of monitoring provider answering system messages be incorporated into the Plan's quality improvement program to ensure regular review, opportunities for improvement are identified and timely actions to resolve issues are taken.

Plan's Compliance Effort: The Plan stated that, with input from the appropriate committees, it had collaborated with its Delegate to implement the following actions to address and correct the stated deficiency:

Provision of Instructions to Providers regarding After-Hours Coverage and Messaging

By August 1, 2005, the Delegate will conduct a mailing to all participating clinicians to provide clear and detailed instructions regarding the requirement to provide 24 hour, 7-days per week coverage for patients and appropriate after hours messaging, specifically:

- After-hours coverage and messaging must include directions for an enrollee, in the event of an emergency, to contact 911 or go to the nearest Emergency Room.
- In addition, one the following options should be included:
  - Answering service that can contact the clinician directly on behalf of the enrollee
  - A covering provider and instructions on how to contact that provider.
  - Provision of a cell/pager number by which the enrollee can contact the provider.
  - Information and telephone number for any local Crisis Support Organization(s).

Monitoring the Presence and Content of Provider Answering System Messages

- Current high volume audit process will be revised to include a provision for confirming the presence and content of provider answering systems and messaging. Non-compliant providers will be referred to Clinical Network Services for the implementation of a corrective action plan.
- Providers wishing to participate in the Delegate network will be reviewed to ensure that coverage and messaging requirements are in place.
- All newly credentialed clinicians will receive a fax reminder of their requirements for 24 hour, 7 days a week coverage as part of the New Provider Welcome Call.
- Routine interactions with clinicians will include the confirmation of appropriate after-hours coverage and messaging, with tracking and follow-up as appropriate.
- An annual After-Hours telephone survey of a random sample of network clinicians will be conducted beginning 4th quarter 2005.

Monitoring Timeliness of Providers' Responses to Messages Left by Enrollees

- Member grievances regarding clinicians not returning calls in a timely manner will be analyzed quarterly.
- Data will be collected and analyzed from all Delegate departments regarding providers that do not return telephone calls.
- An annual random survey of providers assessing timeliness in returning telephone calls will be conducted beginning 4th quarter 2005.

Policy and Procedure/Quality Improvement

The Plan stated that its Delegate presented the results of the Mental Health Parity Focused Survey to the Access & Availability Work Group on May 18, 2005. The Plan also presented the results of the Mental Health Parity Focused Survey to the Behavioral Health Oversight Committee, a multidisciplinary committee comprised of both Plan and Delegate leadership, on May 31, 2005. Based on workgroup recommendations, the Delegate has enhanced its policies to outline the monitoring process. These policies and procedures will be presented to the Delegate's Quality Improvement Committee on June 17, 2005 for formal approval and then filed with the Department as an amendment.

Reporting and Oversight

The Plan also provided scheduling details for its quarterly, semi-annual and annual oversight of the monitoring activities, which will be reported to and discussed by appropriate work groups and committees.

The Plan submitted the following documents:

- Detailed Corrective Action Plan listing Activity, Implementation Date, Delegate Evidence of Correction and Plan Oversight Activity
- Delegate Policy and Procedure: 100.0.08.9 Access to Behavioral Health Services
- Delegate Policy and Procedure: 200.3.18.5 Treatment Record Documentation Standards and Clinician/Facility Site Audits
- Delegate Access and Availability Work Group Meeting Minutes – May 18, 2005
- Plan Access and Availability Work Group Meeting Agenda – June 13, 2005
- Plan Behavioral Health Oversight Committee Agenda– May 31, 2005
- Clinician After-Hours Message Monitoring Form

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been corrected.

The Department finds that the Plan has implemented a well-designed and fully detailed monitoring system to ensure that providers' provisions for after-hour services are reasonable and that providers respond to enrollee messages in a timely manner. During its next Routine Medical Survey, the Department will review the results of the Plan's monitoring activities as well as committee minutes demonstrating the Plan's implementation of any required corrective actions.

B. UTILIZATION MANAGEMENT / BENEFIT COVERAGE

Deficiency 2: The Plan incorrectly and inappropriately denies payment for emergency claims. [Section 1371.37 and Section 1371.4]

Documents Reviewed:

- Emergency room claims from June through December 2004

Department Findings: The Department randomly selected 18 ER claims from non-participating providers and 20 ER claims from participating providers.

Two of the 18 non-participating providers' ER claims were denied for administrative reasons (e.g., coordination of benefits and duplicate claims) and were disqualified for review. Four (4) of the remaining 16 non-participating providers' claims were from county facilities. A total of 16 non-participating ER claims were reviewed.

Six (6) of the 20 participating providers' ER claims were denied for administrative reasons (e.g., carve-out services and duplicate claims) and were disqualified for review. A total of 14 participating ER claims were reviewed.

The Department found that the Plan inappropriately denied 8 of 30 or approximately one-fourth (27%) of the ER claims reviewed.

The Department's findings are summarized below in Table 3.

TABLE 3: EMERGENCY ROOM CLAIMS DENIALS

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# (%) COMPLIANT	# (%) DEFICIENT
Non-Participating Provider ER Claims	16	Appropriate denial	9 (56 %)	7 (43%)
*County Facilities	4	Appropriate denial	4	2
Participating Provider ER Claims	14	Appropriate denial	13 (93 %)	1 (7 %)
Total no. of Files	30		22 (73%)	8 (27%)

* Four of the non-participating ER claims were from county facility providers

The Plan delegates claims processing and management to the Delegate. The following are the Delegate's claims processing guidelines for ER claims.

(1) Division of Financial Responsibility: ER claims containing service items that are not the Delegate's financial responsibility (e.g., EKG, X-ray, etc.) are forwarded to the Plan for additional processing after mental health ER services have been paid by the Delegate.

(2) Medical Review: ER claims with medical records attached are forwarded for medical review to determine medical necessity.

(3) Automatic Denial: ER claims are automatically denied if the provider billing data do not match the data in the Delegate's claims payment system, with the exception of non-participating billing providers. Non-participating ER claims are to be manually processed.

The Department found that the Plan did not pay claims in accordance with its policies. A claim from a non-participating provider that qualified for manual processing was denied for lack of authorization. Five (5) non-participating ER claims that were the Delegate's financial responsibility were forwarded to the Plan for payment. The Plan also denied three (3) out of 30 claims with medical records attached for lack of authorization. Plan staff agreed with the Department's findings and stated that it has initiated staff training regarding correct application of ER payment policies.

Implications: Incorrect denial of payment for health care services to which enrollees are entitled breaches the agreement between the enrollee and the plan for covered services, may create a barrier to future services based on previously denied payments and may result in providers inappropriately billing enrollees for these services.

Corrective Action:

(1) The Plan shall develop and implement an internal audit program designed to monitor compliance with its ER claims processing policies and procedures.

(2) Specific audit criteria shall include, but not be limited to:
   a. total number and percent of ER claims that qualified for automatic payment
   b. total number and percent of ER claims that qualified for and were automatically paid
   c. total number and percent of ER claims that were referred for medical review
   d. accuracy of medical review determination, based on statutory requirements

(3) Files selected for audit should include appealed cases as well as initial determinations.

(4) File sampling method should be proportional to the total number of facility types (participating, county, other) from which the Plan receives ER claims. For example, if claims from county facilities account for 20% of the Plan's total ER claims, then 20% of the ER claims selected for audit should be from county facilities.

(5) The Plan shall establish an implementation date for the audit program, which should be no later than two (2) months from the date of the Preliminary Report, and include the implementation date in its response to the Preliminary Report. Audit results should be reported to the Department, within a reasonable time frame, after the first three (3) and six (6) months of the implementation date.

The Department recommends that the Plan incorporate the results of this internal audit program into its quality improvement program to ensure that findings are regularly reviewed, opportunities for improvement identified, and timely action is taken to resolve issues.

Plan's Compliance Effort: The Plan stated that it collaborated with its Delegate to implement the following actions to address and correct the stated deficiency:

Process Improvement/Policy and Procedure

Delegate Actions

- Reviewed existing ER claims policy and procedure with claims staff.
- Revised data entry procedures to ensure that the ER claims edit is accurately adjudicated and conducted training to improve the accuracy of ER claims data entry.
- Implemented improved processes for forwarding to the Plan ER claims for which the Delegate and the Plan have co-liability and revised the corresponding policy, procedure and tracking documents.
- Implemented dedicated sorting, batching and scanning processes in the mailroom to ensure that all ER claims are identified and receive special handling.
- Revised Claims Processing Department policy and procedure and the Emergency Room Determination Table and trained Claims staff on the revised processes.

Plan Actions

- Revised the Delegate HMO/POS to clarify Delegate and Plan claim processing responsibilities and the Job Aid to clearly identify all revenue codes and CPT codes that are Delegate responsibility and reviewed the changes with staff.
- Revised and reviewed with staff the policy on Delegate/Plan claim responsibilities.
- Initiated a process to confirm receipt of all claims forwarded by the Delegate.
- Established improved claims workflows to confirm all claims forwarded to the Plan from the Delegate were accurately entered into the Plan's system.
- Revised the Plan's Condition Code document to further delineate all revenue codes and CPT codes under the Delegate's responsibility.

Internal Audit Program

- Implemented an expanded Internal Audit Program for Data Entry to include a dedicated review of ER claims after the data entry process is complete.
- Increased the Delegate audit sample of claims forwarded to the Plan from 5% to 25% to better assess that claims were forwarded to the Plan correctly.
- Developed an additional tracking report to monitor the ER claim forwarding process.
- Created an audit tool to be initiated by the Delegate and forwarded weekly to the Plan for further review that incorporates the following audit criteria:
  - number and percent of ER claims that qualified for automatic payment,
  - number and percent of ER claims that qualified for and were automatically paid,
  - number and percent of ER claims that were referred for medical review,
  - accuracy of medical review decisions (reviewed by clinicians, reported to Claims).

The Plan stated that the audit will include both initial and appealed cases and that sampling will be proportional to the number of facility types from which ER claims are received.

Reporting

The Plan stated that it and its Delegate will incorporate the results of the Internal Audit Program into their respective quality improvement programs to ensure that findings are regularly reviewed, opportunities for improvement identified, and timely action is taken to resolve issues. Findings will be reviewed by appropriate internal staff and committees

The Plan stated that audit results and minutes of committees which review findings will be reported to the Department as requested on September 15 and December 15, 2005.

The Plan submitted the following documents:

- Delegate Policy and Procedure: 700.0.05.10 Review/Handling of Emerg. Svcs. Claims
- Delegate Policy and Procedure: Forwarding Process to Plan
- Plan Policy: The Delegate
- Plan Condition Code: B405
- Plan Job Aid: The Delegate HMO/POS
- Training Documentation
- Delegate/Plan ER Claims Quality Assurance Rollup template
- Plan and Delegate Executive Summary of Emergency Claims Audit template
- Delegate/Plan ER Claims Quality Assurance Rollup
- Delegate/Plan Emergency Claims Determination Tables and Audit Check off List Tools
- Delegate/Plan ER Claims Quality Assurance Rollup Tool
- Accuracy of Medical Review for ER Claims Audit Worksheet
- Plan Learning Performance Quality (LPQ) Audit Procedures of ER Mental Health Claims
- Plan and Delegate Executive Summary of Emergency Claims Audit Report template
- Delegate Policy and Procedure, Emergency Services Claims: UM Process
- Plan UM Emergency Services Policy

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been corrected.

The Department finds that the Plan has implemented improved policies and procedures and has instituted an appropriate auditing system to ensure correct adjudication of ER claims. The Department will review the Plan's scheduled reports of audit results as they are submitted to confirm the Plan's progress in improving adjudication. Additionally, during its next Routine

Medical Survey, the Department will review a sample of claims to assess appropriateness of the adjudication decisions.

C. SURVEY CONCLUSIONS

The Department has completed its Focused Survey of the Plan. The Department will continue to monitor the Plan's compliance with the provisions of the Parity Act through its Routine Medical Surveys, which are conducted at least once every three (3) years.

The Department will develop a Summary Report that aggregates and analyzes the Parity Focused Survey results of all plans surveyed by Fall 2005. The Summary Report will be available to the plans and to the public through the Department's Public File.

A P P E N D I X A

METHODOLOGY & PARAMETERS

A. Review Methodology

The Department conducted a Focused Survey of the Plan from March 21 to March 24, 2005, at the Delegate's offices in San Diego, California, to evaluate the Plan's compliance with Section 1374.72. The Department conducted the survey utilizing the clinical expertise of three licensed mental health professionals, including a board-certified psychiatrist, a doctoral-level psychologist and a licensed clinical social worker.

Survey activities included the review of plan documents, enrollee case files, and claims. The Surveyors conducted interviews with officers and staff from the Plan and its Delegate. Surveyors also telephoned 35 participating providers to assess appointment availability and evaluate the providers' after-hours telephone message in regard to the provision of emergency services. Each survey activity is described in greater detail below.

Review of Plan documents – The Department reviewed a number of additional materials to assess various aspects of Plan compliance, for example:

- Policies and procedures for all related activities
- Internal performance standards and performance reports
- Communications regarding benefits
  - Explanation of coverage
  - Explanation of benefits
- Materials demonstrating continuity and coordination of care
  - Reports on inpatient admissions, office visits and other services provided
  - Clinical practice guidelines and protocols
  - Case management program descriptions and case files
- Reports on access and availability of services
  - Number and geographic distribution of clinicians, facilities and programs
  - Appointment availability
  - Timeliness of answering the triage and referral telephones
- Reports demonstrating the Plan's oversight of any activities performed by its Delegate

Review of enrollee case files: Prior to the on-site visit, the Department requested logs for a number of Plan activities, e.g., utilization review, claims processing, case management, etc. From these, the Department selected samples of case files for a comprehensive review. Review focused on measures such as appropriateness of denials of services, timeliness of decision-making, and coordination of care, as well as the appropriate exchange of information among providers.

The review of utilization management files was performed with the participation of Plan staff. Table 4 below displays the categories of utilization management files reviewed and the sample sizes selected.

TABLE 4: FILES REVIEWED

CATEGORY OF FILE	SAMPLE SIZE
Utilization Management - Medical Necessity Denials for Children with Autism or Seriously Emotionally Disturbed Children	8
Utilization Management - Medical Necessity Denials for Other Individuals	20
Utilization Management - Benefit Denials for Children with Autism or Seriously Emotionally Disturbed Children	8
Utilization Management - Benefit Denials for Other Individuals	20
Utilization Management - Denials of Non-Formulary Pharmaceuticals	10
Continuity and Coordination of Care – Case Management Files	5

Review of claims – Prior to the on-site visit, the Department requested claims listings. From these, the Department selected samples of claims for comprehensive review. Review focused on measures such as the appropriateness of denial and the accuracy of payment based on mandated parity benefits. The review of claims files was performed with the participation of Plan staff. Table 5 below displays the categories of claims reviewed and the sample sizes selected.

TABLE 5: CLAIMS FILES REVIEWED

CATEGORY OF CLAIM	SAMPLE SIZE
Claims for emergency services from non-participating providers	16
Claims for emergency services from participating providers	14

Interviews – The Department interviewed staff from both the Plan and Delegate to augment the review of documents and obtain a comprehensive picture of Plan activities surrounding the implementation of Section 1374.72, as well as to discuss the specific files, claims and documents the Department reviewed. The list of individual officers and staff members interviewed, along with their respective titles, may be found in Appendix C. The list of the Department's survey team members that conducted the interviews may be found in Appendix D.

B. Utilization Management File Review Parameters

The parameters assessed during the review of each file included (as appropriate to each sample type):

- Diagnoses
- Accuracy of case categorization (parity vs. non-parity)
- Decision rendered/action taken by plan (approval or denial)
- Adequacy of clinical information obtained to support decision-making
- Documentation of rationale supporting the decision rendered
- Accuracy of decision based upon statutory requirements and
- Consistency between decision and communication sent to the affected practitioner/provider and member

C. Claims Review Parameters

The parameters assessed during the review of claims included:

- Diagnoses
- Accuracy of claim categorization (parity vs. non-parity; participating vs. non-participating; and emergency vs. non-emergency)
- Adequacy of administrative and clinical information obtained to support denial decision-making
- Appropriateness of denial
- Documentation of referral to medical review prior to denial decision rendered
- Accuracy of documented denial reason based upon plan policies regarding claim processing
- Accuracy of payment based on mandated parity benefits and
- Appropriateness and accuracy of communication sent to the affected practitioner/provider and enrollee

A P P E N D I X B

OVERVIEW OF PLAN OPERATIONS

A. Plan Profile

The tables below summarize the information submitted to the Department by the Plan and its Delegate in response to the Pre-Survey Questionnaire:

PLAN PROFILE

Type of Plan	**Full Service Plan**	
Specialized Health Care Service Plan(s) or Mental Health Plan(s) with which the Plan Contracts for (i.e., delegates) Provision of any 1374.72 Services as of March 10, 2004	**Knox-Keene Licensed Behavioral Health Plan**	**Enrollees**
	US Behavioral Health Care of California	2,396,653(99%)
	Carved out to other plans through three-party agreements	19,880(<1%)
	Total	2,416,533 (100%)
Number of Enrollees Covered by Mental Health Parity as of February 2005	**Product Lines**	**Enrollees**
	Group HMO/POS	1,190,267
	Group PPO	586,108
	Individual HMO	34,185
	Individual PPO	296,787
	Healthy Families HMO	34,384
	Healthy Families EPO	4,802
	Total	2,416,533
PPO	Statewide	
HMO	Alameda Butte Contra Costa Fresno Kern (partial) Kings Los Angeles Madera Marin Merced	Nevada (partial) Orange Placer (partial) Riverside (partial) Sacramento San Bernardino (partial) San Diego (partial) San Francisco San Joaquin San Luis Obispo	San Mateo Santa Barbara Santa Clara Santa Cruz Solano Sonoma Stanislaus Tulare Ventura Yolo

CalPERS	Colusa: EPO El Dorado: HMO (partial) El Dorado: EPO (partial) Glenn: HMO	Imperial: HMO Lake: EPO Mariposa: HMO Mendocino: EPO	Napa: HMO Plumas: EPO Sierra: EPO
Healthy Families	Alameda: HMO Butte: EPO Contra Costa: HMO (being deleted effective July 1, 2005) Calaveras: EPO Del Norte: EPO El Dorado: HMO (partial) Fresno: HMO Glenn: EPO Humboldt: EPO Imperial: EPO King: EPO (effective July 1, 2005) Lake: EPO Los Angeles: HMO	Madera: EPO (effective July 1, 2005) Marin: HMO Mendocino: EPO Merced: EPO (effective July 1, 2005) Nevada: HMO (partial) Orange: HMO Placer: HMO (partial) Riverside: HMO (partial) Sacramento: HMO San Benito: EPO San Bernardino: HMO (partial) San Diego: EPO San Francisco: HMO San Joaquin: HMO	San Mateo: EPO (being deleted effective July 1, 2005) Santa Barbara: HMO Santa Cruz: HMO Santa Clara: HMO Shasta: EPO Solano: HMO Sonoma: HMO Tehama: EPO Tulare: HMO Tuolumne: EPO Ventura: HMO Yolo: HMO Yuba: EPO

Plan Identification of Enrollees Eligible for Parity Services
Adults: The Delegate initially identifies an adult as eligible for parity benefits from the diagnosis that the provider puts on the claim. Subsequently, the provider may indicate a parity diagnosis orally through case review or in writing through treatment plans or claims submission.
Seriously Emotionally Disturbed Children: The Delegate initially identifies enrollees, ages 17 and under, as seriously emotionally disturbed and eligible for parity benefits when it receives a claim for any covered DSM-IV diagnosis. Subsequently, the provider may indicate the diagnosis orally through case review or in writing through treatment plans or claims submission.

MENTAL HEALTH PROVIDER NETWORK

Practitioners that Treat Adults	Number in the Network
Psychiatrists	1122
Doctoral-level psychologists	2210
Mental health nurse practitioners with furnishing numbers	0
Other mental health nurse practitioners	8
Marriage and Family Therapists (MFT)	2878
Licensed Clinical Social Workers (LCSW)	1352
Total	**7570**

Practitioners that Treat Children and Adolescents	Number in the Network
Psychiatrists	348
Doctoral-level psychologists	987
Mental health nurse practitioners with furnishing numbers	0
Other mental health nurse practitioners	3
MFTs	1363
LCSWs	669
Total	**3370**

Programs and Institutional Providers that Treat Adults	Number in the Network
Acute inpatient units—voluntary admissions	95
Acute inpatient units—involuntary admissions	NA
Crisis treatment centers/programs	11
Intensive outpatient treatment programs/partial hospitalization	167
Residential treatment programs	62
Eating disorder programs	9
Others	40

Programs and Institutional Providers that Treat Children and Adolescents	Number in the Network
Acute inpatient units—voluntary admissions	38
Acute inpatient units—involuntary admissions	NA
Crisis treatment centers/programs	5
Intensive outpatient treatment programs/partial hospitalization	72
Residential treatment programs	22
Eating disorder programs	10
Others:	9

ACCESS AND AVAILABILITY STANDARDS

Provider Availability Standards For Adult, Child, and Adolescent Providers					
Type of Practitioner	Ratio of Practitioners to Enrollees	Geographic Availability			Percent of Open Practices
		95% within:			
		Urban	Suburban	Rural	
Psychiatrists	0.5 / 1000	10 mi	20 mi	30 mi	No standard set
Doctoral-level psychologists	1.75 / 1000	10 mi	20 mi	30 mi	
Mental health nurse practitioners with furnishing numbers	n/a	n/a	n/a	n/a	
Master's prepared therapists	1.75 / 1000	10 mi	20 mi	30 mi	

Appointment Availability Standards For Adult, Child, and Adolescent Providers	
Type of Services	Standard
Non-life-threatening Emergency	100% within 6 hours
Urgent Care	100% within 48 hours
Initial Post-hospitalization Follow-up Visit	47% within 7 days of discharge
Routine Visit	100% offered within 10 business days (90% kept)

Telephone Responsiveness Standards	
Telephone Availability	**Standard**
Triage and Referral Average Speed of Answer	80% answered in 30 seconds or less
Triage and Referral Abandonment Rate	5% or less
Member Services Average Speed of Answer	80% answered in 30 seconds or less
Member Services Abandonment Rate	5% or less

B. Overview of Programs

The table below presents a brief overview of the Plan's operations in each of the four program areas that were examined during the Department's focused survey.

OVERVIEW OF PROGRAMS

PROGRAM	DESCRIPTION
ACCESS AND AVAILABILITY	• Enrollees receive a detailed description of parity and non-parity benefits in the Plan's Evidence of Coverage/Schedule of Benefits • Enrollees can access outpatient services in two ways: (1) Enrollees can access psychiatrist services directly without going through the Delegate's Customer Service/Care Management system. The diagnosis on the claim is used to determine whether the member is receiving services for a parity diagnosis or non-parity diagnosis. (2) Enrollees can access psychiatrists and therapists through the Delegate's intake referral system. Enrollees simply seeking the name(s) of participating providers are served by an intake referral specialist. If the enrollee needs urgent or emergent services, a care manager, who is a licensed mental health therapist, helps the enrollee obtain services. • Callers are told that their first visit will be considered a parity visit for purposes of calculating benefits (e.g., co-payments). Following the first visit, benefits will depend on the diagnosis established by the clinician. Enrollees are encouraged to discuss questions further with the clinician. • The Delegate contracts with acute general hospitals and free-standing psychiatric hospitals for inpatient care. It does not contract with county mental health facilities. The Delegate has authorization procedures and standards for Urgent Care (seen within 48 hours) and non-life-threatening emergent care (6 hours). Enrollees calling customer services to report urgent or emergent situations are routed to care managers. The care managers assess each enrollee's needs and work with the enrollee and other involved individuals (e.g., family members) to ensure that those needs are met. Enrollees with life-threatening emergencies are directed to the emergency room. Care managers may notify the police to accompany enrollees to the hospital or assist in other manners to facilitate the process.

ACCESS AND AVAILABILITY (Continued)	• In addition to contracting with individual providers and hospitals, the Delegate also contracts with programs for partial hospitalization, intensive outpatient treatment, residential treatment (available only to those enrollees whose employers chose the benefit), eating disorders and autism. • The Delegate has standards for appointment availability and monitors against these standards at least annually. Additionally, the Delegate monitors post-hospitalization follow-up visits for up to six months post-discharge through its care management system. The Delegate monitors the responsiveness of the customer services lines on a monthly basis.
UTILIZATION MANAGEMENT	• Approximately half of the Plan's enrollees participate in point-of-service or preferred provider option plans that allow them to receive services without undergoing utilization management processes and/or to receive services outside the network. "Opting out" typically results in a higher deductible and/or co-payment. • Psychiatrists are not required to obtain prior authorization for outpatient services; however, they must obtain authorization to provide diagnostic testing and to admit enrollees into inpatient or outpatient programs. • All other providers receive one (1) session for assessing the patient without a requirement for authorization from the Delegate. Subsequent sessions are subject to utilization management and are authorized in multiples of six (6) sessions. • Services for autism and pervasive developmental delay are provided by both the Plan and its Delegate. (1) The Plan and its medical groups authorize and monitor the provision of physical therapy, occupational therapy and speech and language therapy to children with autism-spectrum disorders. (2) The Delegate authorizes and monitors services for the evaluation and diagnosis of autism and the treatment of autism, with the exception of physical and speech and language therapy. The enrollee's PCP makes referrals for these services • The Delegate employs a care manager with expertise in the services available to parents through the Delegate and through other community resources. • Care managers understand the individual education plan (IEP) process and refer parents to resources that can advocate for them with the school. Regional Center representatives have visited the Delegate to explain the purposes and services offered by the centers.

CONTINUITY AND COORDINATION OF CARE	• The Delegate provides for continuity and coordination of care within the mental health system through a care management program. • There is an "Inpatient Follow-up Program" for enrollees discharged following an acute psychiatric hospitalization. It provides a standardized process for the post-discharge management of all patients hospitalized for mental health conditions and defines additional interventions for those at highest risk for re-hospitalization. This protocol provides for telephone contact with discharged patients at seven (7), 30, 50 and 90 days following hospital discharge and at 180 days for higher risk patients. • In addition to routine care management, enrollees may be identified for "Complex Care Management" on the basis of complexity of diagnosis, frequent hospitalizations or other indications of high risk. Any enrollee can be internally referred for this service level. Specific clinically qualified staff are assigned exclusively to complex care management, which involves more intensive efforts to facilitate care and which may include extra Delegate-initiated contacts with the enrollees and providers. Note: All out-of-state care coordination is done by the Plan, regardless of diagnosis. • Both to promote appropriate referral to the Delegate from the Plan's and to assist with collaborative disease management, the Delegate provides a "Primary Care Physician Hotline" on a 24/7 basis. In addition to referral information, the PCPs can obtain as-needed consultation with an on-call Delegate medical director that is board-certified in psychiatry. • The Delegate's *Clinician Manual* sets explicit expectations for all mental health providers to communicate with PCPs and also among themselves on shared cases. The Delegate's *Medical Interface Manual* further emphasizes standards for coordination of care, with specific sections on "Medical Management Interface Procedures" and "Interface with Primary Care Physicians." • The Plan and its Delegate have developed a care management system to coordinate medical and mental health care for enrollees requiring both types of care. (1) When a Delegate care manager identifies a potentially significant medical condition, the care manager contacts his/her Plan counterpart to coordinate care with the enrollee's PCP. The Delegate refers to this process as a "stoplight workflow," i.e. a protocol that requires that the Plan be contacted prior to proceeding with any further mental health arrangements. (2) The Delegate /Plan "Co-management of Co-existing Conditions" protocol provides for the communication between Delegate and Plan care managers in the event that the enrollee: a) has a diagnosis of Diabetes Mellitus or intractable Chronic Pain, or b) has an unstable Axis II condition. • In 2004, the Plan assessed the effectiveness of its strategies with the Delegate to improve mental health provider communication with PCPs through the "2004 HMO PCP Evaluations of Utilization and Continuity of Care for Behavioral Health." The results of this survey were presented to Delegate and Plan committees responsible for overseeing quality of care.

CONTINUITY AND COORDINATION OF CARE (Continued)	• There is an ongoing subgroup of the Plan's Behavioral Health QI Workgroup that focuses on improvement in communications among mental and physical health providers. In particular, they have focused on pediatricians' dissatisfaction with psychiatrists' communications, and the need for improved communication about enrollees receiving narcotic medications from multiple practitioners. • Guidelines for clinical practice include criteria for referrals by a PCP to a mental health provider, and criteria for a non-physician mental health provider to refer to a psychiatrist for the consideration of medication. • The Delegate has adopted widely recognized best practice guidelines for all parity diagnoses. For children, the Delegate uses American Academy of Child and Adolescent Psychiatry (AACAP) standards. For adults, it uses the American Psychiatric Association (APA) standards for all diagnoses except obsessive-compulsive disorder, for which the Expert Consensus Guideline Series is employed. • The Delegate monitors participating provider performance using the HEDIS antidepressant medication management measure. • The Plan and its Delegate have distributed specific depression guidelines-related materials, known as the "Depression Tool Kit" to all Plan physicians. A similar toolkit has been developed for pediatricians to present attention deficit/hyperactivity disorder guidelines.
DELEGATION MANAGEMENT	• The subcontract between the Plan and its Delegate accurately describes parity requirements and the responsibilities of the Delegate in meeting those requirements.

A P P E N D I X C

LIST OF STAFF INTERVIEWED

The following are the key Plan officers and staff who participated in the on-site survey at the Plan's administrative office on March 21 through March 24, 2005.

BLUE SHIELD OF CALIFORNIA	
Name	**Title**
Gifford Boyce-Smith, MD,	Sr. Medical Director, Quality Management
Andrew Halpert, MD,	Sr. Medical Director, Network Medical Management
Lyle Swallow, Esq.	Associate General Counsel
Salina Wong, Pharm. D.	Director, Clinical Pharmacy Services
Wendy Lekavich	Director, Provider Relations
Sharon Baughn,	Director, Appeals and Grievances
Shelly Spahr	Manager, Regulatory Compliance
Shari Glago	Network Manager, Behavioral Health
Jan Lea, Supervisor	Network Delegation Oversight
Dolores Aisenberg	Manager, Quality Compliance
Theresa Clarke	Manager, Quality Compliance
Pat Rux	Benefits
Joanne Trenam	Manager, Claims
Jerry Cropley	Supervisor, Claims
Karyn Lankford	Claims
Fiona Wilmot, M.D.	Medical Policy
Maria Hotz, R.N.	Manager, Medical Policy
Paula Ackerman	Manager, Case Management
Jacqueline Ejuwa, Pharm.D.	Manager, Clinical Drug Authorization
Rob Geyer	VP, Customer Service
Stephanie Greenwood	Manager, Customer Service

PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA, INC.	
Name	**Title**
James Davis	President
Richard Jimenez, MD	Chief Medical Director
Michael Bailey, MD	Associate Medical Director
Tracy Miller	Sr. Director, Operations
Pamela Simpson	Director, Quality Improvement
Nancy Cottingham	Sr. Director, Clinical Operations
Eileen Innecken	Compliance Officer
Kimberly Davis	Sr. Director, Clinical Network Services
Jennifer Thompson	Compliance Specialist
Marilyn Jasper	Claims Manager
Suzanne McCarthy	Customer Service Manager
Elisa Mullen	Clinical Program Manager
Darrell Rison	Intake Manager
Gina Fejeran	Claims Supervisor
Angelina Hancock	Grievances and Appeals Supervisor
E.J. Morton	Quality Improvement Specialist
Elisa Mullen	Clinical Program Manager
B.J. Gaines	Customer Service Specialist
Kathy Pinchetti	Care Manager

A P P E N D I X D

LIST OF SURVEYORS

The Department's Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Name	**Title**
Bobbie Reagan	Assistant Deputy Director, HMO Help Center
Andrew George	Counsel, HMO Help Center
Tom Gilevich	Counsel, HMO Help Center
Dan McCord, MBA	Senior Health Care Service Plan Analyst
Ann Vuletich, MPH	Staff Health Care Service Plan Analyst

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Name	**Title**
Rose Leidl, RN	Contract Manager
Bernice Young	Program Director
Ruth Martin, MPH, MBA	Parity Survey Team Leader
Patricia Allen, M.Ed.	Data Analyst
Marshall Lewis, MD	Benefit Structure and Enrollee Information Surveyor
Sharon A. Shueman, Ph.D.	Utilization Management Surveyor
Nikki Cavalier. LCSW, CPHQ	Access and Availability Surveyor

A P P E N D I X E

STATUTES AND REGULATIONS APPLICABLE TO THE IDENTIFIED DEFICIENCES

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan does not ensure that providers' provision for after-hour services is reasonable and that providers' respond to enrollee messages in a timely manner. [Rule 1300.67.2(b) and Rule 1300.74.72(f)]

Citations:
Rule 1300.67.2(b)
Hours of operation and provision for after-hour services shall be reasonable.

Rule 1300.74.72(f)
A health plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set for in Health and Safety Code section 1374.72…

B. UTILIZATION MANAGEMENT

Deficiency 2: The Plan incorrectly and inappropriately denies payment for emergency claims. [Section 1371.37 and Section 1371.4]

Citation:
Section 1371.37
"(a) A health care service plan is prohibited from engaging in an unfair payment pattern, as defined in this section.
(c) An "unfair payment pattern," as used in this section, means the following:
(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays.
(3) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.
(4) Failing on a repeated basis to automatically include the interest due on claims pursuant to section 1371

Section 1371.4
"Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that the health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition."

A P P E N D I X F

LIST OF ACRONYMS

Acronyms	Definition
CAP	Corrective Action Plan
dba	Doing Business As
DMH	Department of Mental Health
DOI	Department of Insurance
EOC	Evidence of Coverage
ER	Emergency Room
HMO	Health Maintenance Organization
LCSW	Licensed Clinical Social Worker
IPA	Independent Practice (or Provider) Association
MFT	Marriage and Family Therapist
MSA	Metropolitan Statistical Area
PCP	Primary Care Physician
PMG	Primary Medical Group
POS	Point of Service
PPO	Preferred Provider Organization
UM	Utilization Management

A P P E N D I X G

THE SURVEY PROCESS AND INSTRUCTIONS FOR THE PLAN'S CORRECTIVE ACTIONS AND RESPONSES

The following provides detail on the required survey activities and the order in which they are undertaken by the Department, as well as instructions for how plans must institute corrective actions and prepare their responses to the Preliminary Report and the Final Report. The table below summarizes the survey activities and the corresponding timeframes.

FOCUSED SURVEY PROCESS

SURVEY ACTIVITY	TIMEFRAME
Focused Survey On-Site Visit Conducted	As needed
Preliminary Report due from the Department to the Plan	30 – 45 calendar days from the last day of the on-site visit
Response due from Plan to the Department [Section 1380(h)(2)] *(Evidence that the deficiency has been fully corrected must be included)*	45 calendar days from date of receipt of Focused Survey Preliminary Report
Final Report due from the Department to the Plan	Within 170 days from the last day of the on-site visit
Response from Plan to Department on any matters in Final Report	Within 10 calendar days from receipt of Final Report. Response is included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the on-site visit

Survey Preparation

The Department conducts a Focused Survey of a licensed health care service plan on an adhoc basis in order to evaluate a plan's compliance with certain Knox-Keene requirements and address specific issues identified by the Department. This Focused Survey specifically evaluates a plan's compliance with Section 1374.72.

Prior to the visit, the Department supplies the Plan with a Pre-On-Site Visit Questionnaire and a list of materials that the Plan is required to submit to the Department prior to the on-site visit. These materials are reviewed by the survey team to provide them with an overview of plan operations, policies and procedures in preparation for the visit. The Plan is also advised of the materials (e.g., case files, reports) the surveyors will review during the on-site visit so that these will be readily available for the survey team.

On-site Visit

During the on-site visit, the survey team reviews materials and conducts interviews with Plan staff and possibly with providers.

Preliminary Report

Specific to this Mental Health Parity Focused Survey, the Department provides the Plan with a Preliminary Report within 40 days of the on-site visit. The Preliminary Report details the Department's survey findings and the required corrective actions.

Plan's Response to the Preliminary Report

In accordance with Section 1380(h)(2), the Plan has 45 calendar days from the date of receipt of the Preliminary Report to file a written response. Preliminary and Final Reports are "deficiency-based" reports; therefore, only specific areas found by the Department to be in need of improvement are included in these Reports. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance in other areas.

All deficiencies cited in the Preliminary Report require corrective actions by the Plan. The Department specifies corrective actions in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Plan must implement all required actions in the manner prescribed by the Department. The Plan must submit evidence that the required actions have been or are being implemented when the Plan submits its 45-day response.

The Plan's response should include the following information for each deficiency identified in the Preliminary Report:

(1) The Plan's response to the Department's findings of deficiencies;

(2) The Plan's response to the Department's specified corrective actions, which include a corrective action plan (CAP);

(3) Whether the CAP is fully implemented at the time of the Plan's response. If the CAP is fully implemented, the Plan should provide documents or other evidence that the deficiencies have been corrected; and

(4) If the CAP cannot be fully implemented by the time the Plan submits its response, the Plan should submit evidence that remedial action has been initiated and is on the way to achieving compliance. Please include a time-schedule for implementing the corrective action and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the Plan's response indicates that the development and implementation of corrective actions will not be completed by the time the Plan files its 45-day response, the Plan should file any policies and procedures required for implementation as Plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the Plan should file both a clean and redline version of revised policies and procedures through the Department's web portal. The Plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the web portal. The Plan is not to submit its entire response to the Preliminary Report through the Department's web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review of the Plan's response to the Preliminary Report, the Department will publish a Final Report. This report will contain the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response and the Department's determination concerning the adequacy of the Plan's response. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The Final Report will first be issued to the Plan, followed by a copy to the public file. The Final Report will be issued to the public file not more than 180 days from the conclusion of the on-site survey.

The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after the reports are issued.